State of New Jersey
Department of Labor
Division of Workers' Compensation
PO Box 381
Trenton, New Jersey 08625-0381

DEPENDENCY CLAIM PETITION

(Do Not Fill In)
CASE No. _____
D.O. _____

PETITIONER

SOCIAL SECURITY NUMBER

NAME

ADDRESS (Including County)

ATTORNEY FOR PETITIONER

☐ NEW JERSEY REGISTRATION NUMBER ☐ SSN ☐ FEDERAL EMPLOYER ID NUMBER

NAME

ADDRESS

TELEPHONE (Area Code)

VS

RESPONDENT

NAME

ADDRESS (including County)

INSURANCE CARRIER

NAME (Indicate if Not Covered or self-insured)

ADDRESS

CARRIER'S CLAIM FILE NUMBER

TO THE DIVISION OF WORKERS' COMPENSATION:

Petitioner, alleging that Decedent hereinafter named sustained personal injury by an accident or occupational disease arising out of and in the course of employment with Respondent, resulting in death, respectfully states:

DECEDENT

SOCIAL SECURITY NUMBER

NAME

ADDRESS (Including County)

DEPENDENTS (At time of death)

1. Name:	Age	Date of Birth	Relationship
2.			
3.			
4.			

USE SEPARATE SHEET IF REQUIRED

Sex	Date of Birth	Date Injury Occurred	Date Employer Had Knowledge of Injury	Date Injury Reported	Date Stopped Work	Date Returned to Work	Date of Death

Occupation and Type of Work

How Injury Occurred (If Occupational Disease Give Periods of Exposure)

Occupational Disease ☐ Yes ☐ No

Where

Nature of Injury		Cause of Death	
Medical Expenses $	Burial Expenses $	Payable to	
Gross Weekly Wages $	Rate of Compensation $	Compensation Received for Injury $	Total Dependency Benefits Paid $

Employer Furnished Medical Aid ☐ Yes ☐ No

☐ Demand is hereby made for answers to standard occupational disease interrogatories.

☐ Demand is hereby made for all records of medical treatment, examinations and diagnostic studies.

What other facts are there that you believe important?

In occupational disease claims, list claims against other employers filed or to be filed for the same or similar occupational diseases.

NAME & ADDRESS OF EMPLOYER	DATES OF EMPLOYMENT

Your Petitioner therefore requests that the Division of Workers' Compensation determine the amount of compensation due your Petitioner from said Respondent, under Revised Statutes of New Jersey, Title 34, Chapter 15, and the Acts supplemental thereto and amendatory thereof, and that your Petitioner may be awarded Petitioner's costs in this proceeding, and such other or further relief as may be proper.

_____
(Petitioner)

STATE OF NEW JERSEY
COUNTY OF

Subscribed and sworn or affirmed
to before me this day of
, 20

_____

The foregoing Claim Petition has been presented by the Petitioner to the Division of Workers' Compensation for hearing and determination. Unless an Answer is filed within 30 days of the date of service of the Claim Petition upon you, with the assignment clerk at the office to which the claim is assigned as indicated on the reverse side, and a copy served upon the Petitioner's attorney, THE PETITIONER WILL PROCEED WITH PROOF OF CLAIM ACCORDING TO LAW AND MAY OBTAIN JUDGMENT AGAINST YOU.

The Privacy Act, 5 U.S.C. § 552a, the Social Security Act, 42 U.S.C. § 405, and *N.J.S.A.* 34:15-1 *et seq.* authorize the Division of Workers' Compensation to request that the Petitioner supply the Division with his or her Social Security number for record keeping purposes and cross-matches with the Social Security Administration, Workforce New Jersey, Temporary Disability Insurance and any other proper public purpose.

DIVISION OF WORKERS' COMPENSATION